

Flat Size: 420mm X 298mm    Folded Size: 70mm X 50.83mm

**WATSON PHARMA**  
Revised: July 2007      **IN-5383/S**

**PHYSICIAN LABELING**

**Ogestrel® 0.5/50**  
(Norgestrel and Ethinyl Estradiol Tablets USP,  
0.5 mg/0.05 mg)

**Rx only**

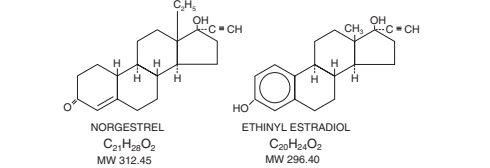
Patients should be counseled that oral contraceptives do not protect against transmission of HIV (AIDS) and other sexually transmitted diseases (STDs) such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.

**DESCRIPTION**

**Ogestrel® 0.5/50** Tablets (norgestrel and ethinyl estradiol tablets USP, 0.5 mg/0.05 mg) provide an oral contraceptive regimen consisting of 21 white tablets followed by 7 peach inert tablets.

Each white tablet, for oral administration contains 0.5 mg of norgestrel, 18,19-Dinorpregn-4-en-20-yn-3-one, 13-ethyl-17-hydroxy-, (17 $\alpha$ -(+)-, a totally synthetic progestogen, and 0.05 mg ethinyl estradiol, 19-Nor-17 $\alpha$ -pregna-1,3,5(10)-trien-20-yne-3,17-diol, and the following inactive ingredients: croscarmellose sodium, lactose, magnesium stearate, microcrystalline cellulose, and povidone.

Each inactive peach tablet, for oral administration, in the 28 day regimen contains the following inactive ingredients: anhydrous lactose, FD&C Yellow No. 6 Lake, lactose monohydrate, magnesium stearate, and microcrystalline cellulose.



**CLINICAL PHARMACOLOGY**

#### Mode of Action

Combination oral contraceptives act by suppression of gonadotropins. Although the primary mechanism of this action is inhibition of ovulation, other alterations include changes in the cervical mucus (which increase the difficulty of sperm entry into the uterus) and the endometrium (which reduce the likelihood of implantation).

#### INDICATIONS AND USAGE

Oral contraceptives are indicated for the prevention of pregnancy in women who elect to use this product as a method of contraception.

Oral contraceptives are highly effective. Table 1 lists the typical accidental pregnancy rates for users of combination oral contraceptives and other methods of contraception. The efficacy of these contraceptive methods, except sterilization, the IUD, and implants depends upon the reliability with which they are used. Correct and consistent use of methods can result in lower failure rates.

Table 1: Percentage Of Women Experiencing An Unintended Pregnancy During The First Year Of Typical Use And The First Year Of Perfect Use Of Contraception And The Percentage Continuing Use At The End Of The First Year. United States.

Method (1)	% of Women Experiencing an Unintended Pregnancy within the First Year of Use <sup>1</sup>		% of Women Continuing Use at One Year <sup>3</sup>	
	(2)	(3)	(4)	
Chance <sup>4</sup>	85	85		
Spermicides <sup>5</sup>	26	6	40	
Periodic abstinence	25	9	63	
Calendar				
Ovulation Method		3		
Sympto-Thermal <sup>6</sup>		2		
Post-Ovulation		1		
Cap <sup>7</sup>				
Parous Women	40	26	42	
Nulliparous Women	20	9	56	
Sponge				
Parous Women	40	20	42	
Nulliparous Women	20	9	56	
Diaphragm <sup>7</sup>	20	6	56	
Withdrawal	19	4		
Condom <sup>8</sup>				
Female (Reality)	21	5	56	
Male	14	3	61	
Pill	5	0.5	71	
Progestin only				
Combined		0.1		
IUD				
Progesterone T	2.0	1.5	81	
Copper T380A	0.8	0.5	78	
LNg 20	0.1	0.1	81	
Depo-Provera®	0.3	0.3	70	
Levonorgestrel Implants (Norplant®)	0.05	0.05	88	
Female Sterilization	0.5	0.5	100	
Male Sterilization	0.15	0.10	100	

Lactation Amenorrhea Method: LAM is a highly effective, temporary method of contraception.<sup>9</sup>

Emergency Contraceptive Pills: Treatment initiated within 72 hours after unprotected intercourse reduces the risk of pregnancy by at least 72%.<sup>10</sup>

Source: Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Stewart F, Cates W, Stewart GK, Kowal D, Guest F. Contraceptive Technology: Seventeenth Revised Edition. New York, NY: Irvington Publishers; 1998.

1 Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

2 Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

3 Among couples attempting to avoid pregnancy, the percentage who continue to use a method for one year.

4 The percents becoming pregnant in columns (2) and (3) are based on data from populations where contraception is not used and from women who cease using contraception in order to become pregnant. Among such populations, about 85% become pregnant within one year. This estimate was lowered slightly (to 80%) to represent the percent who would become pregnant within one year among women now relying on reversible methods of contraception if they abandoned contraception altogether.

- 5 Foams, creams, gels, vaginal suppositories, and vaginal film.
- 6 Cervical mucus (ovulation) method supplemented by calendar in the pre-ovulatory and basal body temperature in the post-ovulatory phases.
- 7 With spermicidal cream or jelly.
- 8 Without spermicides.
- 9 However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches 6 months of age.
- 10 The treatment schedule is one dose within 72 hours after unprotected intercourse, and a second dose 12 hours after the first dose. The FDA has declared the following brands of oral contraceptives to be safe and effective for emergency contraception. Ovaral (1 dose is 2 white pills). Alesse (1 dose is 5 pink pills). Nordette or Leven (1 dose is 4 yellow pills).

- CONTRAINDICATIONS**
- Combination oral contraceptives should not be used in women with any of the following conditions:
- Thrombophlebitis or thromboembolic disorders
  - A past history of deep-vein thrombophlebitis or thromboembolic disorders
  - Cerebral-vascular or coronary-artery disease (current or history)
  - Valvular heart disease with thrombogenic complications
  - Thrombogenic rhythm disorders
  - Major surgery with prolonged immobilization
  - Diabetes with vascular involvement
  - Headaches with focal neurological symptoms
  - Uncontrolled hypertension
  - Known or suspected carcinoma of the breast or personal history of breast cancer
  - Carcinoma of the endometrium or other known or suspected estrogen-dependent neoplasia
  - Undiagnosed abnormal genital bleeding
  - Cholestatic jaundice of pregnancy or jaundice with prior pill use
  - Hepatic adenomas or carcinomas, or active liver disease, as long as liver function has not returned to normal
  - Known or suspected pregnancy
  - Hypersensitivity to any of the components of Ogestrel®

**WARNINGS**

**Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with the extent of smoking (in epidemiologic studies, 15 or more cigarettes per day was associated with a significantly increased risk) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.**

The use of oral contraceptives is associated with increased risks of several serious conditions including venous and arterial thrombotic and thromboembolic events (such as myocardial infarction, thromboembolism, and stroke), hepatic neoplasia, gallbladder disease, and hypertension, although the risk of serious morbidity or mortality is very small in healthy women without underlying risk factors. The risk of morbidity and mortality increases significantly in the presence of other underlying risk factors such as certain inherited or acquired thrombophilias, hypertension, hyperlipidemias, obesity and diabetes. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

The information contained in this package insert is based principally on studies carried out in patients who used oral contraceptives with higher formulations of estrogens and progestogens than those in common use today. The effect of long-term use of the oral contraceptives with lower formulations of both estrogens and progestogens remains to be determined. Throughout this labeling, epidemiological studies reported are of two types: retrospective or case control studies and prospective or cohort studies. Case control studies provide a measure of the relative risk of disease, namely, a ratio of the incidence of a disease among oral contraceptive users to that among non-users. The relative risk does not provide information on the actual clinical occurrence of a disease. Cohort studies provide a measure of attributable risk, which is the difference in the incidence of disease between oral contraceptive users and non-users. The attributable risk does provide information about the actual occurrence of a disease in the population. For further information, the reader is referred to a text on epidemiological methods.

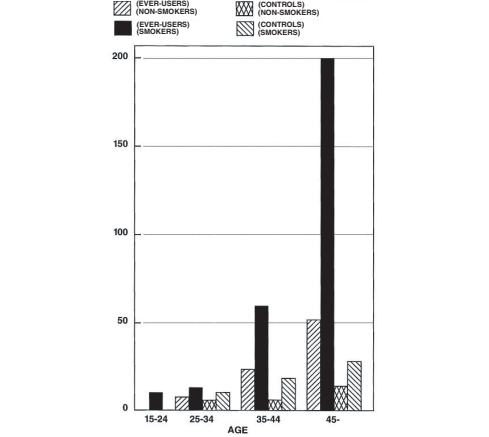
#### 1. Thromboembolic Disorders and Other Vascular Problems

##### a. Myocardial infarction

An increased risk of myocardial infarction has been attributed to oral contraceptive use. This risk is primarily in smokers or women with other underlying risk factors for coronary-artery disease such as hypertension, hypercholesterolemia, morbid obesity, and diabetes. The relative risk of heart attack for current oral contraceptive users has been estimated to be 2 to 6. The risk is very low under the age of 30.

Smoking in combination with oral contraceptive use has been shown to contribute substantially to the incidence of myocardial infarction in women in their mid-thirties or older with smoking accounting for the majority of excess cases. Mortality rates associated with circulatory disease have been shown to increase substantially in smokers over the age of 35 and non-smokers over the age of 40 (Table II) among women who use oral contraceptives.

**CIRCULATORY DISEASE MORTALITY RATES PER 100,000 WOMAN YEARS BY AGE, SMOKING STATUS AND ORAL CONTRACEPTIVE USE**



Oral contraceptives may compound the effects of well-known risk factors, such as hypertension, diabetes, hyperlipidemias, age, and obesity. In particular, some progestogens are known to decrease HDL cholesterol and cause glucose intolerance, while estrogens may create a state of hyperinsulinism. Oral contraceptives have been shown to increase blood pressure among users (see section 9 in **WARNINGS**). Similar effects on risk factors have been associated with an increased risk of heart disease. Oral contraceptives must be used with caution in women with cardiovascular disease risk factors.

#### b. Thromboembolism

An increased risk of venous thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Case control studies have found the relative risk of users compared to non-users to be 3 for the first episode of superficial venous thrombosis, 4 to 11 for deep-vein thrombosis or pulmonary embolism, and 1.5 to 6 for women with predisposing conditions for venous thromboembolic disease. Cohort studies have shown the relative risk to be somewhat lower, about 3 for new cases and about 4.5 for new cases requiring hospitalization. The approximate incidence of deep vein thrombosis and pulmonary embolism in users of low dose (<50 mcg ethinyl estradiol) combination oral contraceptives is up to 4 per 10,000 woman-years compared to 0.5-3 per 10,000 woman-years for non-users. However, the incidence is less than that associated with pregnancy (6 per 10,000 woman-years). The risk of thromboembolic disease due to oral contraceptives is not related to length of use and disappears after pill use is stopped.

A 2- to 4-fold increase in relative risk of postoperative thromboembolic complications has been reported with the use of oral contraceptives. The relative risk of venous thrombosis in women who have predisposing conditions is twice that of women without such medical conditions. If feasible, oral contraceptive users should be discontinued at least 4 weeks prior to any major surgery or to prolonged immobilization. The relative risk of thromboembolism and during and following prolonged immobilization. Since the immediate postpartum period is also associated with an increased risk of thromboembolism, oral contraceptives should be started no earlier than 4 weeks after delivery in women who elect not to breast-feed.

#### c. Cerebrovascular diseases

Oral contraceptives have been shown to increase both the relative and attributable risks of cerebrovascular events (thrombotic and hemorrhagic strokes), although, in general, the risk is greatest among older (>35 years), hypertensive women who also smoke. Hypertension was found to be a risk factor for both users and non-users for both types of strokes, while smoking interacted to increase the risk for hemorrhagic strokes.

In a large study, the relative risk of thrombotic strokes has been shown to range from 3 for normotensive users to 14 for users with severe hypertension. The relative risk of hemorrhagic stroke is reported to be 1.2 for non-smokers who used oral contraceptives, 2.6 for smokers who did not use oral contraceptives, 7.6 for smokers who used oral contraceptives, 1.8 for normotensive users, and 25.7 for users with severe hypertension. The attributable risk is also greater in older women. Oral contraceptives also increase the risk for stroke in women with other underlying risk factors such as certain inherited or acquired thrombophilias, hyperlipidemias, and obesity. Women with migraine (particularly migraine with aura) who take combination oral contraceptives may be at an increased risk of stroke.

#### d. Dose-related risk of vascular disease from oral contraceptives

A positive association has been observed between the amount of estrogen and progestogen in oral contraceptives and the risk of vascular disease. A decline in serum high-density lipoproteins (HDL) has been reported with many progestational agents. A decline in serum high-density lipoproteins has been associated with an increased incidence of ischemic heart disease. Because estrogens increase HDL cholesterol, the net effect of an oral contraceptive depends on a balance achieved between doses of estrogen and progestogen and the nature and absolute amount of progestogen used in the contraceptive. The amount of both hormones should be considered in the choice of an oral contraceptive.

Minimizing exposure to estrogen and progestogen is in keeping with good principles of therapeutics. For any particular estrogen/progestogen combination, the dosage regimen prescribed should be one which contains the least amount of estrogen and progestogen that is compatible with a low failure rate and the needs of the individual patient. New acceptors of oral contraceptive agents should be started on preparations containing the lowest estrogen content which is judged appropriate for the individual patient.

#### e. Persistence of risk of vascular disease

There are two studies which have shown persistence of risk of vascular disease for ever-users of oral contraceptives. In a study in the United States, the risk of developing myocardial infarction after discontinuing oral contraceptives persists for at least 9 years for women 40-49 years who had used oral contraceptives for 5 or more years, but this increased risk was not demonstrated in other age groups. In another study in Great Britain, the risk of developing cerebrovascular disease persisted for at least 6 years after discontinuation of oral contraceptives, although excess risk was very small. However, both studies were performed with oral contraceptive formulations containing 50 mcg or higher of estrogen.

#### 2. Estimates of Mortality from Contraceptive Use

One study gathered data from a variety of sources which have estimated the mortality rate associated with different methods of contraception at different ages (Table III). These estimates include the combined risk of death associated with contraceptive methods plus the risk attributable to pregnancy in the event of method failure. Each method of contraception has its specific benefits and risks. The study concluded that with the exception of oral contraceptive users 35 and older who smoke and 40 and older who do not smoke, mortality associated with all methods of birth control is less than that associated with childbirth. The observation of a possible increase in risk of mortality with age for oral contraceptive users is based on data gathered in the 1970's—but not reported until 1983. However, current clinical practice involves the use of lower estrogen dose formulations combined with careful restriction of oral contraceptive use to women who do not have the various risk factors listed in this labeling.

Because of these changes in practice and, also, because of some limited new data which suggest that the risk of cardiovascular disease with the use of oral contraceptives may now be less than previously observed, the Fertility and Maternal Health Drugs Advisory Committee was asked to review the topic in 1989. The Committee concluded that although cardiovascular-disease risks may be increased with oral contraceptive use after age 40 in healthy non-smoking women (even with the newer low-dose formulations), there are greater potential health risks associated with pregnancy in older women and with the alternative surgical and medical procedures which may be necessary if such women do not have access to effective and acceptable means of contraception.

Therefore, the Committee recommended that the benefits of oral contraceptive use by healthy non-smoking women over 40 may outweigh the possible risks. Of course, older women, as all women who take oral contraceptives, should take the lowest possible dose formulation that is effective.

**TABLE III: ANNUAL NUMBER OF BIRTH-RELATED OR METHOD-RELATED DEATHS ASSOCIATED WITH CONTROL OF FERTILITY PER 100,000 NONSTERILE WOMEN, BY FERTILITY-CONTROL METHOD AND ACCORDING TO AGE**

Method of control and outcome	15-19	20-24	25-29	30-34	35-39	40-44
No fertility-control methods*	7.0	7.4	9.1	14.8	25.7	28.2
Oral contraceptives						
non-smoker**	0.3	0.5	0.9	1.9	13.8	31.6
Oral contraceptives smoker**	2.2	3.4	6.6	13.5	51.1	117.2
IUD**	0.8	0.8	1.0	1.0	1.4	1.4
Condom*	1.1	1.6	0.7	0.2	0.3	0.4
Diaphragm/spermicide*	1.9	1.2	1.2	1.3	2.2	2.8
Periodic abstinence*	2.5	1.6	1.6	1.7	2.9	3.6

\* Deaths are birth-related

\*\* Deaths are method-related

Adapted from H.V. Ory, Family Planning Perspectives, 15:57-63, 1983.

#### 3. Carcinoma of the Reproductive Organs and Breasts

Numerous epidemiological studies have been performed on the incidence of breast, endometrial, ovarian and cervical cancer in women using oral contraceptives. Although the risk of having breast cancer diagnosed may be slightly increased among current and recent users of combined oral contraceptives (RR=1.24), this excess risk decreases over time after combination oral contraceptive discontinuation and by 10 years after cessation the increased risk disappears. The risk does not increase with duration of use and no consistent relationships have been found with dose or type of steroid. The patterns of risk are also similar regardless of a woman's reproductive history or her family breast cancer history. The subgroup for whom risk has been found to be significantly elevated is women who first used oral contraceptives before age 20, but because breast cancer is so rare at these young ages, the number of cases attributable to this early oral contraceptive use is extremely small. Breast cancers diagnosed in current or previous oral contraceptive users tend to be less clinically advanced than in never-users. Women who currently have or have had breast cancer should not use oral contraceptives because breast cancer is a hormone sensitive tumor.

Some studies suggest that oral contraceptive use has been associated with an increase in the risk of cervical intraepithelial neoplasia or invasive cervical cancer in some populations of women. However, there continues to be controversy about the extent to which such findings may be due to differences in sexual behavior and other factors.

In spite of many studies of the relationship between oral contraceptive use and breast and cervical cancers, a cause-and-effect relationship has not been established.

#### 4. Hepatic Neoplasia

Benign hepatic adenomas are associated with oral contraceptive use, although the incidence of benign tumors is rare in the United States. Indirect calculations have estimated the attributable risk to be in the range of 3.3 cases/100,000 for users, a risk that increases after 4 or more years of use. Rupture of rare, benign, hepatic adenomas may cause death through intra-abdominal hemorrhage.

Studies from Britain have shown an increased risk of developing hepatocellular carcinoma in long-term (>8 years) oral contraceptive users.

However, these cancers are extremely rare in the U.S., and the attributable risk (the excess incidence) of liver cancers in oral contraceptive users approaches less than one per million users.

#### 5. Ocular Lesions

There have been clinical case reports of retinal thrombosis associated with the use of oral contraceptives that may lead to partial or complete loss of vision. Oral contraceptives should be discontinued if there is unexplained partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions. Appropriate diagnostic and therapeutic measures should be undertaken immediately.

#### 6. Oral Contraceptive Use Before or During Early Pregnancy

Extensive epidemiological studies have revealed no increased risk of birth defects in infants born to women who have used oral contraceptives prior to pregnancy. Studies also do not suggest a teratogenic effect, particularly insofar as cardiac anomalies and limb-reduction defects are concerned, when taken inadvertently during early pregnancy (see **CONTRAINDICATIONS** section).

The administration of oral contraceptives to induce withdrawal bleeding should not be used as a test for pregnancy. Oral contraceptives should not be used during pregnancy to treat threatened or habitual abortion.

It is recommended that for any patient who has missed 2 consecutive periods, pregnancy should be ruled out. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Oral contraceptive use should be discontinued if pregnancy is confirmed.

#### 7. Gallbladder Disease

Earlier studies have reported an increased lifetime relative risk of gallbladder surgery in users of oral contraceptives and estrogens. More recent studies, however, have shown that the relative risk of developing gallbladder disease among oral contraceptive users may be minimal. The recent findings of minimal risk may be related to the use of oral contraceptive formulations containing lower hormonal doses of estrogens and progestogens.

#### 8. Carbohydrate and Lipid Metabolic Effects

Oral contraceptives have been shown to cause glucose intolerance in a significant percentage of users. Oral contraceptives containing greater than 75 mcg of estrogens cause hyperinsulinism, while lower doses of estrogen cause less glucose intolerance. Progestogens increase insulin secretion and create insulin resistance, this effect varying with different progestational agents. However, in the non-diabetic woman, oral contraceptives appear to have no effect on fasting blood glucose. Because of these demonstrated effects, prediabetic and diabetic women should be carefully observed while taking oral contraceptives.

A small proportion of women will have persistent hypertriglyceridemia while on the pill. As discussed earlier (see **WARNINGS** 1a and 1d), changes in serum triglycerides and lipoprotein levels have been reported in oral contraceptive users.

#### 9. Elevated Blood Pressure

Women with significant hypertension should not be started on hormonal contraception. An increase in blood pressure has been reported in women taking oral contraceptives, and this increase is more likely in older oral contraceptive users and with continued use. Data from the Royal College of General Practitioners and subsequent randomized trials have shown that the incidence of hypertension increases with increasing quantities of progestogens.

Women with a history of hypertension or hypertension-related diseases, or renal disease, should be encouraged to use another method of contraception. If women with hypertension elect to use oral contraceptives, they should be monitored closely, and if significant elevation of blood pressure occurs, oral contraceptives should be discontinued (see **CONTRAINDICATIONS** section). For most women, elevated blood pressure will return to normal after stopping oral contraceptives, and there is no difference in the occurrence of hypertension among ever- and never-users.

#### 10. Headache

The onset or exacerbation of migraine or development of headache with a new pattern that is recurrent, persistent, or severe requires discontinuation of oral contraceptives and evaluation of the cause. (See **WARNINGS** 1c.)

#### 11. Bleeding Irregularities

Breakthrough bleeding and spotting are sometimes encountered in patients on oral contraceptives, especially during the first 3 months of use. The type and dose of progestogen may be important. If bleeding persists or recurs, non-hormonal causes should be considered and adequate diagnostic measures taken to rule out malignancy or pregnancy in the event of breakthrough bleeding, as in the case of any abnormal vaginal bleeding. If pathology has been excluded, time or a change to another formulation may solve the problem. In the event of amenorrhea, pregnancy should be ruled out.

Some women may encounter post-pill amenorrhea or oligomenorrhea (possibly with anovulation), especially when such a condition was pre-existent.

#### 12. Ectopic Pregnancy

Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

#### PRECAUTIONS

##### 1. General

Patients should be counseled that oral contraceptives do not protect against transmission of HIV (AIDS) and other sexually transmitted diseases (STDs) such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.

#### 2. Physical Examination and Follow-Up

A periodic personal and family medical history and complete physical examination are appropriate for all women, including women using oral contraceptives. The physical examination, however, may be deferred until after initiation of oral contraceptives if requested by the woman and judged appropriate by the clinician. The physical examination should include special reference to blood pressure, breasts, abdomen and pelvic organs, including cervical cytology, and relevant laboratory tests. In case of undiagnosed, persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be conducted to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules should be monitored with particular care.

#### 3. Lipid Disorders

Women who are being treated for hyperlipidemias should be followed closely if they elect to use oral contraceptives. Some progestogens may elevate LDL levels and may render the control of hyperlipidemias more difficult. (See **WARNINGS** 1d.)

In patients with familial defects of lipoprotein metabolism receiving estrogen containing preparations, there have been case reports of significant elevations of plasma triglycerides leading to pancreatitis.

#### 4. Liver Function

If jaundice develops in any woman receiving such hormonal contraceptives, the medication should be discontinued. Steroid hormones may be poorly metabolized in patients with impaired liver function.

#### 5. Fluid Retention

Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention.

#### 6. Emotional Disorders

Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug related. Women with a history of depression should be carefully observed and the drug discontinued if significant depression occurs.

#### 7. Contact Lenses

Contact-lens wearers who develop visual changes or changes in lens tolerance should be assessed by an ophthalmologist.

#### 8. Gastrointestinal Motility

Diarrhea and/or vomiting may reduce hormone absorption.

#### 9. Drug Interactions

*Changes in contraceptive effectiveness associated with coadministration of other products:* Contraceptive effectiveness may be reduced when hormonal contraceptives are coadministered with antibiotics, anticonvulsants, and other drugs that increase the metabolism of contraceptive steroids. This could result in unintended pregnancy or breakthrough bleeding. Examples include rifampin, barbiturates, phenylbutazone, phenytoin, carbamazepine, felbamate, oxcarbazepine, topiramate, and griseofulvin. It may take several weeks until enzyme induction has completely subsided, depending on dosage, duration of use, and rate of elimination of the inducing substance.

Several cases of contraceptive failure and breakthrough bleeding have been reported in the literature with concomitant administration of antibiotics such as ampicillin and tetracyclines. However, clinical pharmacology studies investigating drug interactions between combined oral contraceptives and these antibiotics have reported inconsistent results.

Several of the anti-HIV protease inhibitors have been studied with coadministration of oral combination hormonal contraceptives; significant changes (increase and decrease) in the plasma levels of the estrogen and progestin have been noted in some cases. The safety and efficacy of oral contraceptive products may be affected with coadministration of anti-HIV protease inhibitors. Health care professionals should refer to the label of the individual anti-HIV protease inhibitors for further drug-drug interaction information.

Herbal products containing St. John's Wort (Hypericum perforatum) may induce hepatic enzymes (cytochrome P 450) and p-glycoprotein transporter and may reduce the effectiveness of contraceptive steroids. This may also result in breakthrough bleeding.

#### *Increase in plasma levels associated with coadministered drugs:*

Coadministration of atrovastatin and certain oral contraceptives containing ethinyl estradiol increase AUC values for ethinyl estradiol by approximately 20%. Ascorbic acid and acetaminophen may increase plasma ethinyl estradiol levels, possibly by inhibition of conjugation. CYP 3A4 inhibitors such as itraconazole or ketoconazole may



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ovulation and conception prior to initiation of medication should be considered. The dosage of Ogestrel is one white tablet daily for 21 consecutive days, followed by one peach inert tablet daily for 7 consecutive days, according to prescribed schedule.

It is recommended that Ogestrel tablets be taken at the same time each day. During the first cycle of medication, the patient is instructed to begin taking Ogestrel on the first Sunday after the onset of menstruation. If menstruation begins on a Sunday, the first tablet (white) is taken that day. One white tablet should be taken daily for 21 consecutive days followed by one peach inert tablet daily for 7 consecutive days. Withdrawal bleeding should usually occur within three days following discontinuation of white tablets and may not have finished before the next pack is started. During the first cycle, contraceptive reliance should not be placed on Ogestrel until a white tablet has been taken daily for 7 consecutive days and a non-hormonal back-up method of birth control should be used during those 7 days. The possibility of ovulation and conception prior to initiation of medication should be considered.

The patient begins her next and all subsequent 28-day courses of tablets on the same day of the week (Sunday) on which she began her first course, following the same schedule: 21 days on white tablets—7 days on peach inert tablets. If in any cycle the patient starts tablets later than the proper day, she should protect herself against pregnancy by using a non-hormonal back-up method of birth control until she has taken a white tablet daily for 7 consecutive days.

When the patient is switching from a 21-day regimen of tablets, she should wait 7 days after her last tablet before she starts Ogestrel. She will probably experience withdrawal bleeding during that week. She should be sure that no more than 7 days pass after her previous 21-day regimen. When the patient is switching from a 28-day regimen of tablets, she should start her first pack of Ogestrel on the day after her last tablet. She should not wait any days between packs. The patient may switch any day from a progestin-only pill and should begin Ogestrel the next day. If switching from an implant or injection, the patient should start Ogestrel on the day of implant removal or, if using an injection, the day the next injection would be due. In switching from a progestin-only pill, injection, or implant, the patient should be advised to use a non-hormonal back-up method of birth control for the first 7 days of tablet-taking.

If spotting or breakthrough bleeding occurs, the patient is instructed to continue on the same regimen. This type of bleeding is usually transient and without significance; however, if the bleeding is persistent or prolonged, the patient is advised to consult her health care professional. Although pregnancy is unlikely if Ogestrel is taken according to directions, if withdrawal bleeding does not occur, the possibility of pregnancy must be considered. If the patient has not adhered to the prescribed schedule (missed one or more tablets or started taking them on a day later than she should have), the probability of pregnancy should be considered at the time of the first missed period and appropriate diagnostic measures taken. If the patient has adhered to the prescribed regimen and misses two consecutive periods, pregnancy should be ruled out. Hormonal contraceptives should be discontinued if pregnancy is confirmed.

For additional patient instructions regarding missed tablets, see the “WHAT TO DO IF YOU MISS PILLS” section in the DETAILED PATIENT LABELING below.

Any time the patient misses two or more white tablets, she should also use another method of contraception until she has taken a white tablet daily for seven consecutive days. If the patient misses one or more peach tablets, she is still protected against pregnancy **provided** she begins taking white tablets again on the proper day.

If breakthrough bleeding occurs following missed white tablets, it will usually be transient and of no consequence. The possibility of ovulation increases with each successive day that scheduled white tablets are missed.

Ogestrel may be initiated no earlier than day 28 postpartum in the non-lactating mother due to the increased risk for thromboembolism (see **CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS** concerning thromboembolic disease). The patient should be advised to use a non-hormonal back-up method for the first 7 days of tablet-taking. However, if intercourse has already occurred, the possibility of ovulation and conception prior to initiation of medication should be considered.

In the case of first-trimester abortion, if the patient starts Ogestrel immediately, additional contraceptive measures are not needed.

#### HOW SUPPLIED

Ogestrel® 0.5/50 Tablets (norgestrel and ethinyl estradiol tablets USP, 0.5 mg/0.05 mg): Each white tablet is unscored, round in shape, with **848** debossed on one side and **WATSON** on the other side, and contains 0.5 mg norgestrel and 0.05 mg ethinyl estradiol. Ogestrel® 0.5/50 is packaged in cartons of three tablet dispensers. Each tablet dispenser contains 21 white (active) tablets and 7 peach (inert) tablets. Inert tablets are unscored, round in shape with **WATSON** debossed on one side and **P1** on the other side.

**Store at controlled room temperature, 20°C to 25°C (68°F to 77°F).**

**References available upon request.**

#### BRIEF SUMMARY PATIENT PACKAGE INSERT

**This product (like all oral contraceptives) is intended to prevent pregnancy. Oral contraceptives do not protect against transmission of HIV (AIDS) and other sexually transmitted diseases (STDs) such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.**

Oral contraceptives, also known as “birth-control pills” or “the pill,” are taken to prevent pregnancy, and when taken correctly, have a failure rate of approximately 1% per year when taken without missing any pills. The typical failure rate of large numbers of pill users is approximately 5% per year when women who miss pills are included. For most women oral contraceptives are also free of serious or unpleasant side effects. However, forgetting to take pills considerably increases the chances of pregnancy.

For the majority of women, oral contraceptives can be taken safely. But there are some women who are at high risk of developing certain serious diseases that can be life-threatening or may cause temporary or permanent disability or death. The risks associated with taking oral contraceptives increase significantly if you:

- smoke
- have high blood pressure, diabetes, high cholesterol, or an abnormal tendency to form blood clots, or are obese
- have or have had clotting disorders, heart attack, stroke, angina pectoris, cancer of the breast or sex organs, jaundice, malignant or benign liver tumors

You should not take the pill if you suspect you are pregnant or have experienced vaginal bleeding.

Although cardiovascular disease risks may be increased with oral contraceptive use after age 40 in healthy, non-smoking women (even with the newer low-dose formulations), there are also greater potential health risks associated with pregnancy in older women.

**Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral contraceptive use. This risk increases with age and with the amount of smoking (15 or more cigarettes per day has been associated with a significantly increased risk) and is quite marked in women over 35 years of age. Women who use oral contraceptives should not smoke.**

Most side effects of the pill are not serious. The most common such effects are nausea, vomiting, bleeding between menstrual periods, weight gain, breast tenderness, and difficulty wearing contact lenses. These side effects, especially nausea and vomiting, may subside within the first 3 months of use. The serious side effects of the pill occur very infrequently, especially if you are in good health and do not smoke. However, you should know that the

following medical conditions have been associated with or made worse by the pill:

1. Blood clots in the legs (thrombophlebitis), lungs (pulmonary embolism), stroke or rupture of a blood vessel in the brain (stroke), blockage of blood vessels in the heart (heart attack and angina pectoris) or other organs of the body. As mentioned above, smoking increases the risk of heart attacks and strokes and subsequent serious medical consequences. Women with migraine also may be at increased risk of stroke with pill use.
2. Liver tumors, which may rupture and cause severe bleeding. A possible but not definite association has been found with the pill and liver cancer. However, liver cancers are extremely rare. The chance of developing liver cancer from using the pill is thus even rarer.
3. High blood pressure, although blood pressure usually returns to normal when the pill is stopped.

The symptoms associated with these serious side effects are discussed in the detailed leaflet given to you with your supply of pills. Notify your health care professional if you notice any unusual physical disturbances while taking the pill. In addition, drugs such as rifampin, as well as some anti-convulsants and some antibiotics, and possibly herbal preparations containing St. John’s Wort (Hypericum perforatum), may decrease oral contraceptive effectiveness.

Breast cancer has been diagnosed slightly more often in women who use the pill than in women of the same age who do not use the pill. This very small increase in the number of breast cancer diagnoses gradually disappears during the 10 years after stopping use of the pill. It is not known whether the difference is caused by the pill. It may be that women taking the pill are examined more often, so that breast cancer is more likely to be detected. You should have regular breast examinations by a healthcare provider and examine your own breasts monthly. Tell your healthcare provider if you have a family history of breast cancer or if you have had breast nodules or an abnormal mammogram. Women who currently have or have had breast cancer should not use hormonal contraceptives because breast cancer is usually a hormone-sensitive tumor.

Some studies have found an increase in the incidence of cancer or precancerous lesions of the cervix in women who use the pill. However, this finding may be related to factors other than the use of the pill.

Taking the combination pill provides some important non-contraceptive health benefits. These include less painful menstruation, less menstrual blood loss and anemia, fewer pelvic infections, and fewer cancers of the ovary and the lining of the uterus.

Be sure to discuss any medical condition you may have with your health care provider. Your health care provider will take a medical and family history before prescribing oral contraceptives and will examine you. The physical examination may be delayed to another time if you request it and the health care provider believes that it is appropriate to postpone it. You should be re-examined at least once a year while taking oral contraceptives. The detailed patient information leaflet gives you further information which you should read and discuss with your health care provider.

**This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect against transmission of HIV (AIDS) and other sexually transmitted diseases such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.**

#### DETAILED PATIENT LABELING

**This product (like all oral contraceptives) is intended to prevent pregnancy. Oral contraceptives do not protect against transmission of HIV (AIDS) and other sexually transmitted diseases (STDs) such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.**

#### INTRODUCTION

Any woman who considers using oral contraceptives (the birth-control pill or the pill) should understand the benefits and risks of using this form of birth control. This leaflet will give you much of the information you will need to make this decision and will also help you determine if you are at risk of developing any of the serious side effects of the pill. It will tell you how to use the pill properly so that it will be as effective as possible. However, this leaflet is not a replacement for a careful discussion between you and your health-care provider. You should discuss the information provided in this leaflet with him or her, both when you first start taking the pill and during your revisits. You should also follow your health-care provider’s advice with regard to regular check-ups while you are on the pill.

#### EFFECTIVENESS OF ORAL CONTRACEPTIVES

Oral contraceptives or “birth-control pills” or “the pill” are used to prevent pregnancy and are more effective than most other non-surgical methods of birth control. When they are taken correctly, without missing any pills the chance of becoming pregnant is less than 1% per year. Typical failure rates are approximately 5% per year. The chance of becoming pregnant increases with each missed pill during the menstrual cycle.

In comparison, typical failure rates for other methods of birth control during the first year of use are as follows:

IUD: 0.1-2%	Female condom alone: 21%
Depo-Provera® (injectable progestogen): 0.3%	Cervical cap
Norplant® System (levonorgestrel implants): 0.05%	Never given birth: 20%
Diaphragm with spermicides: 20%	Given birth: 40%
Spermicides alone: 26%	Periodic abstinence: 25%
Male condom alone: 14%	No methods: 85%
Vaginal sponge: 20 to 40%	Withdrawal: 19%
Female sterilization: 0.5%	Male sterilization: 0.15%

#### WHO SHOULD NOT TAKE ORAL CONTRACEPTIVES

**Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral contraceptive use. This risk increases with age and with the amount of smoking (15 or more cigarettes per day has been associated with a significantly increased risk) and is quite marked in women over 35 years of age. Women who use oral contraceptives should not smoke.**

Some women should not take the pill. You should not take the pill if you have any of the following conditions:

- History of heart attack or stroke
- History of blood clots in the legs (thrombophlebitis), lungs (pulmonary embolism), or eyes
- History of blood clots in the deep veins of your legs
- Chest pain (angina pectoris)
- Known or suspected breast cancer or cancer of the lining of the uterus, cervix, or vagina or certain hormonally-sensitive cancers
- Unexplained vaginal bleeding (until a diagnosis is reached by your health care professional)
- Liver tumor (benign or cancerous)
- Yellowing of the whites of the eyes or of the skin (jaundice) during pregnancy or during previous use of the pill
- Known or suspected pregnancy
- A need for surgery with prolonged bedrest
- Heart valve or heart rhythm disorders that may be associated with formation of blood clots
- Diabetes affecting your circulation
- Headaches with neurological symptoms
- Uncontrolled high blood pressure
- Active liver disease with abnormal liver function tests
- Allergy or hypersensitivity to any of the components of Ogestrel

Tell your health care professional if you have any of these conditions. Your health care professional can recommend another method of birth control.

#### OTHER CONSIDERATIONS BEFORE TAKING ORAL CONTRACEPTIVES

Tell your health care professional if you or any family member has ever had:

- Breast nodules, fibrocystic disease of the breast, an abnormal breast X-ray or mammogram
- Diabetes
- Elevated cholesterol or triglycerides
- High blood pressure
- An abnormal tendency to form blood clots
- Migraine or other headaches or epilepsy
- Depression
- Gallbladder, liver, heart, or kidney disease
- History of scanty or irregular menstrual periods

Women with any of these conditions should be checked often by their health care professional if they choose to use oral contraceptives. Also, be sure to inform your health care professional if you smoke or are on any medications.

#### RISKS OF TAKING ORAL CONTRACEPTIVES

##### 1. Risk of developing blood clots

Blood clots and blockage of blood vessels are the most serious side effects of taking oral contraceptives and can cause death or serious disability. In particular, a clot in the legs can cause thrombophlebitis and a clot that travels to the lungs can cause a sudden blocking of the vessel carrying blood to the lungs. Rarely, clots occur in the blood vessels of the eye and may cause blindness, double vision, or impaired vision.

If you take oral contraceptives and need elective surgery, need to stay in bed for a prolonged illness or injury, or have recently delivered a baby, you may be at risk of developing blood clots. You should consult your health care professional about stopping oral contraceptives three to four weeks before surgery and not taking oral contraceptives for two weeks after surgery or during bed rest. You should also not take oral contraceptives soon after delivery of a baby. It is advisable to wait for at least four weeks after delivery if you are not breast feeding. If you are breast feeding, you should wait until you have weaned your child before using the pill. (See also the section on breast feeding in **GENERAL PRECAUTIONS**.)

The risk of circulatory disease in oral contraceptive users may be higher in users of high-dose pills (containing 50 micrograms or higher of ethinyl estradiol) and may be greater with longer duration of oral contraceptive use. In addition, some of these increased risks may continue for a number of years after stopping oral contraceptives. The risk of abnormal blood clotting increases with age in both users and nonusers of oral contraceptives, but the increased risk from the oral contraceptive appears to be present at all ages. For women aged 20 to 44, it is estimated that about 1 in 2,000 using oral contraceptives will be hospitalized each year because of abnormal clotting. Among nonusers in the same age group, about 1 in 20,000 would be hospitalized each year. For oral contraceptive users in general, it has been estimated that in women between the ages of 15 and 34 the risk of death due to a circulatory disorder is about 1 in 12,000 per year, whereas for nonusers the rate is about 1 in 50,000 per year. In the age group 35 to 44, the risk is estimated to be about 1 in 2,500 per year for oral contraceptive users and about 1 in 10,000 per year for nonusers.

##### 2. Heart attacks and strokes

Oral contraceptives may increase the tendency to develop strokes (stoppage or rupture of blood vessels in the brain) and angina pectoris and heart attacks (blockage of blood vessels in the heart). Any of these conditions can cause death or serious disability.

Smoking greatly increases the possibility of suffering heart attacks and strokes. Furthermore, smoking and the use of oral contraceptives greatly increase the chances of developing and dying of heart disease.

Women with migraine (especially migraine with aura) who take oral contraceptives also may be at higher risk of stroke.

##### 3. Gallbladder disease

Oral contraceptive users probably have a greater risk than non-users of having gallbladder disease. This risk may be related to pills containing high doses of estrogens.

##### 4. Liver tumors

In rare cases, oral contraceptives can cause benign but dangerous liver tumors. These benign liver tumors can rupture and cause fatal internal bleeding. In addition, a possible but not definite association has been found with the pill and liver cancers in 2 studies in which a few women who developed these very rare cancers were found to have used oral contraceptives for long periods. However, liver cancers are extremely rare. The chance of developing liver cancer from using the pill is thus even rarer.

##### 5. Cancer of the reproductive organs and breasts

Breast cancer has been diagnosed slightly more often in women who use the pill than in women of the same age who do not use the pill. This small increase in the number of breast cancer diagnoses gradually disappears during the 10 years after stopping use of the pill. It is not known whether the difference is caused by the pill. It may be that women taking the pill are examined more often, so that breast cancer is more likely to be detected. You should have regular breast examinations by a healthcare provider and examine your own breasts monthly. Tell your healthcare provider if you have a family history of breast cancer or if you have had breast nodules or an abnormal mammogram.

Women who currently have or have had breast cancer should not use oral contraceptives because breast cancer is usually a hormone-sensitive tumor.

Some studies have found an increase in the incidence of cancer or precancerous lesions of the cervix in women who use oral contraceptives. However, this finding may be related to factors other than the use of oral contraceptives. There is insufficient evidence to rule out the possibility that the pill may cause such cancers.

##### 6. Lipid metabolism and inflammation of the pancreas

In patients with inherited defects of lipid metabolism, there have been reports of significant elevations in plasma triglycerides during estrogen therapy. This has led to pancreatitis in some cases.

#### ESTIMATED RISK OF DEATH FROM A BIRTH-CONTROL METHOD OR PREGNANCY

All methods of birth control and pregnancy are associated with a risk of developing certain diseases which may lead to disability or death. An estimate of the number of deaths associated with different methods of birth control and pregnancy has been calculated and is shown in the following table.

ANNUAL NUMBER OF BIRTH-RELATED OR METHOD-RELATED DEATHS ASSOCIATED WITH CONTROL OF FERTILITY PER 100,000 NONSTERILE WOMEN, BY FERTILITY-CONTROL METHOD AND ACCORDING TO AGE						
Method of control and outcome	15-19	20-24	25-29	30-34	35-39	40-44
No fertility-control methods*	7.0	7.4	9.1	14.8	25.7	28.2
Oral contraceptives						
non-smoker**	0.3	0.5	0.9	1.9	13.8	31.6
Oral contraceptives						
smoker**	2.2	3.4	6.6	13.5	51.1	117.2
IUD**	0.8	0.8	1.0	1.0	1.4	1.4
Condom*	1.1	1.6	0.7	0.2	0.3	0.4
Diaphragm/spermicide*	1.9	1.2	1.2	1.3	2.2	2.8
Periodic abstinence*	2.5	1.6	1.6	1.7	2.9	3.6
* Deaths are birth-related						
** Deaths are method-related						

In the above table, the risk of death from any birth-control method is less than the risk of childbirth, except for oral contraceptive users over the age of 35 who smoke and pill users over the age of 40 even if they do not smoke. It can be seen in the table that for women aged 15 to 39, the risk

of death was highest with pregnancy (7-26 deaths per 100,000 women, depending on age). Among pill users who do not smoke, the risk of death was always lower than that associated with pregnancy for any age group, except for those women over the age of 40, when the risk increases to 32 deaths per 100,000 women, compared to 28 associated with pregnancy at that age. However, for pill users who smoke and are over the age of 35, the estimated number of deaths exceeds those for other methods of birth control. If a woman is over the age of 40 and smokes, her estimated risk of death is 4 times higher (117/100,000 women) than the estimated risk associated with pregnancy (28/100,000 women) in that age group.

The suggestion that women over 40 who do not smoke should not take oral contraceptives is based on information from older high-dose pills. An Advisory Committee of the FDA discussed this issue in 1989 and recommended that the benefits of oral contraceptive use by healthy, non-smoking women over 40 years of age may outweigh the possible risks. Older women, as all women who take oral contraceptives, should take an oral contraceptive which contains the least amount of estrogen and progestogen that is compatible with the individual patient needs.

#### WARNING SIGNALS

If any of these adverse effects occur while you are taking oral contraceptives, call your health care professional immediately:

- Sharp chest pain, coughing of blood, or sudden shortness of breath (indicating a possible clot in the lung)
- Pain in the calf (indicating a possible clot in the leg)
- Crushing chest pain or heaviness in the chest (indicating a possible heart attack)
- Sudden severe headache or vomiting, dizziness or fainting, disturbances of vision or speech, weakness, or numbness in an arm or leg (indicating a possible stroke)
- Sudden partial or complete loss of vision (indicating a possible clot in the eye)
- Breast lumps (indicating possible breast cancer or fibrocystic disease of the breast; ask your health care professional to show you how to examine your breasts)
- Severe pain or tenderness in the stomach area (indicating a possibly ruptured liver tumor)
- Difficulty in sleeping, weakness, lack of energy, fatigue, or change in mood (possibly indicating severe depression)
- Jaundice or a yellowing of the skin or eyeballs, accompanied frequently by fever, fatigue, loss of appetite, dark-colored urine, or light-colored bowel movements (indicating possible liver problems)

#### SIDE EFFECTS OF ORAL CONTRACEPTIVES

##### 1. Irregular vaginal bleeding

Irregular vaginal bleeding or spotting may occur while you are taking the pills. Irregular bleeding may vary from slight staining between menstrual periods to breakthrough bleeding which is a flow much like a regular period. Irregular bleeding occurs most often during the first few months of oral contraceptive use, but may also occur after you have been taking the pill for some time. Such bleeding may be temporary and usually does not indicate any serious problems. It is important to continue taking your pills on schedule. If the bleeding occurs in more than 1 cycle or lasts for more than a few days, talk to your health care professional.

##### 2. Contact lenses

If you wear contact lenses and notice a change in vision or an inability to wear your lenses, contact your health care professional.

##### 3. Fluid retention

Oral contraceptives may cause edema (fluid retention) with swelling of the fingers or ankles and may raise your blood pressure. If you experience fluid retention, contact your health care professional.

##### 4. Melasma

A spotty darkening of the skin is possible, particularly of the face.

##### 5. Other side effects

Other side effects may include nausea, breast tenderness, change in appetite, headache, nervousness, depression, dizziness, loss of scalp hair, rash, vaginal infections, inflammation of the pancreas, and allergic reactions. If any of these side effects bother you, call your health care professional.

#### GENERAL PRECAUTIONS

##### 1. Missed periods and use of oral contraceptives before or during early pregnancy

There may be times when you may not menstruate regularly after you have completed taking a cycle of pills. If you have taken your pills regularly and miss 1 menstrual period, continue taking your pills for the next cycle but be sure to inform your health care professional. If you have not taken the pills daily as instructed and missed a menstrual period, or if you missed 2 consecutive menstrual periods, you may be pregnant. Check with your health care professional immediately to determine whether you are pregnant. Stop taking oral contraceptives if pregnancy is confirmed.

There is no conclusive evidence that oral contraceptive use is associated with an increase in birth defects when taken inadvertently during early pregnancy. Previously, a few studies had reported that oral contraceptives might be associated with birth defects, but these findings have not been confirmed in more recent studies. Nevertheless, oral contraceptives should not be used during pregnancy. You should check with your health care professional about risks to your unborn child of any medication taken during pregnancy.

##### 2. While breast feeding

If you are breast feeding, consult your health care professional before starting oral contraceptives. Some of the drug will be passed on to the child in the milk. A few adverse effects on the child have been reported, including yellowing of the skin (jaundice) and breast enlargement. In addition, oral contraceptives may decrease the amount and quality of your milk. If possible, do not use oral contraceptives while breast feeding. You should use another method of contraception since breast feeding provides only partial protection from becoming pregnant, and this partial protection decreases significantly as you breast feed for longer periods of time. You should consider starting oral contraceptives only after you have weaned your child completely.

##### 3. Laboratory tests

If you are scheduled for any laboratory tests, tell your health care professional you are taking birth-control pills. Certain blood tests may be affected by birth-control pills.

##### 4. Drug interactions

Certain drugs may interact with birth control pills to make them less effective in preventing pregnancy or cause an increase in breakthrough bleeding. Such drugs include rifampin, drugs used for epilepsy such as barbiturates (for example, phenobarbital), carbamazepine (Tegretol®) is one brand of this drug), and phenytoin (Dilantin® is one brand of this drug), primidone (Mysoline®), topiramate (Topamax®), phenylbutazone (Butazolidin® is one brand), some drugs used for HIV such as ritonavir (Norvir®), modafinil (Provigil®) and possibly certain antibiotics (such as ampicillin and other penicillins, and tetracyclines). Pregnancies and breakthrough bleeding have been reported by users of combined hormonal contraceptives who also used some form of the herbal supplement St. John’s Wort. You may need to use a non-hormonal method of contraception during any cycle in which you take drugs that can make oral contraceptives less effective. Be sure to tell your healthcare provider if you are taking or start taking any other medications, including non-prescription products or herbal products while taking birth control pills.

You may be at higher risk of a specific type of liver dysfunction if you take troleandomycin and oral contraceptives at the same time.

##### 5. Sexually transmitted diseases

**This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect against transmission of HIV (AIDS) and other sexually trans-**

**mitted diseases such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.**

#### HOW TO TAKE THE PILL

#### IMPORTANT POINTS TO REMEMBER

**BEFORE YOU START TAKING YOUR PILLS:**

##### 1. BE SURE TO READ THESE DIRECTIONS:

Before you start taking your pills.

And

Anytime you are not sure what to do.

##### 2. THE RIGHT WAY TO TAKE THE PILL IS TO TAKE ONE PILL EVERY DAY AT THE SAME TIME.

If you miss pills you could get pregnant. This includes starting the pack late.

The more pills you miss, the more likely you are to get pregnant.

##### 3. MANY WOMEN HAVE SPOTTING OR LIGHT BLEEDING, OR MAY FEEL SICK TO THEIR STOMACH DURING THE FIRST 1-3 PACKS OF PILLS.

If you feel sick to your stomach, do not stop taking the pill. The problem will usually go away. If it doesn’t go away, check with your health care professional.

##### 4. MISSING PILLS CAN ALSO CAUSE SPOTTING OR LIGHT BLEEDING, even when you make up these missed pills.

On the days you take 2 pills to make up for missed pills, you could also feel a little sick to your stomach.

##### 5. IF YOU HAVE VOMITING (within 3 to 4 hours after you take your pill), you should follow the instructions for WHAT TO DO IF YOU MISS PILLS. IF YOU HAVE DIARRHEA or IF YOU TAKE SOME MEDICINES, including some antibiotics, your pills may not work as well. Use a back-up non-hormonal method (such as condoms and/or spermicide) until you check with your health care professional.

##### 6. IF YOU HAVE TROUBLE REMEMBERING TO TAKE THE PILL, talk to your health care professional about how to make pill-taking easier or about using another method of birth control.

##### 7. IF YOU HAVE ANY QUESTIONS OR ARE UNSURE ABOUT THE INFORMATION IN THIS LEAFLET, call your health care professional.

#### BEFORE YOU START TAKING YOUR PILLS

##### 1. DECIDE WHAT TIME OF DAY YOU WANT TO TAKE YOUR PILL.

It is important to take it at about the same time every day.

##### 2. LOOK AT YOUR PILL PACK :

The **pill pack** has 21 “active” white pills (with hormones) to take for 3 weeks, followed by 1 week of reminder peach pills (without hormones).

##### 3. ALSO FIND:

- 1) where on the pack to start taking pills, and
- 2) in what order to take the pills (follow the arrows).

